Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00596-429

Combined Assessment Program Review of the Central Texas Veterans Health Care System Temple, Texas

July 15, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: www.va.gov/oig/hotline)

Glossary

AD	advance directive
CAP	Combined Assessment Program
CT	computed tomography
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	Central Texas Veterans Health Care System
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
SCI	spinal cord injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of April 13, 2015.

Review Results: The review covered eight activities. We made no recommendations in the following three activities:

- Medication Management
- Coordination of Care
- Computed Tomography Radiation Monitoring

Recommendations: We made recommendations in the following five activities:

Quality Management: Ensure licensed independent practitioners who perform emergency airway management have the appropriate skills and training. Require the Surgical Work Group to meet monthly. Include required elements in the quality control policy for scanning. Consistently document actions when data analyses indicate problems or opportunities for improvement, and evaluate the actions for effectiveness in the Quality, Safety, and Value; Critical Care; Medical Records; and Infection Prevention and Control Committees and in the Environment of Care Council.

Environment of Care: See recommendations under *Quality Management*.

Advance Directives: Offer patients the opportunity to review, revise, or rescind previously completed advance directives, and document the discussions. Hold advance directive discussions requested by inpatients, and document the discussions.

Surgical Complexity: Ensure respiratory therapy employees have 12-lead electrocardiogram competency assessment and validation completed and documented.

Emergency Airway Management: Revise the emergency airway management policy to include required elements. Ensure initial clinician emergency airway management competency assessment includes evidence of successful demonstration of all required procedural skills on patients. Require that a clinician with emergency airway management privileges or scope of practice or an anesthesiology staff member is available during all hours the facility provides patient care.

Comments

The Acting Veterans Integrated Service Network Director and Acting Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 25–30, for the full text of the Directors' comments.) We consider recommendation 7 closed. We will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Surgical Complexity
- EAM

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2013, FY 2014, and FY 2015 through April 13, 2015, and inspectors conducted the review in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Central Texas Veterans Health Care System, Temple, Texas,* Report No. 12-03744-84, January 7, 2013.)

During this review, we presented crime awareness briefings for 352 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. We distributed an electronic survey to all facility employees and received 496 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.[a]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, 22 credentialing and privileging folders, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key quality, safety, and value functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data. • QM, patient safety, and systems redesign appeared to be integrated.		
	Peer reviewed deaths met selected requirements: • Peers completed reviews within specified timeframes. • The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings. • Involved providers were invited to provide input prior to the final Peer Review Committee determination.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Credentialing and privileging processes met selected requirements: • Facility managers reviewed privilege forms annually and ensured proper approval of revised forms. • Facility managers ensured appropriate privileges for licensed independent practitioners. • Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation. • Facility managers properly maintained licensed independent practitioners' folders.	• Of the 22 licensed independent practitioners' folders reviewed, 21 practitioners' EAM privileges were not appropriate for their skills and training.	**1.** We recommended that facility managers ensure that licensed independent practitioners who perform emergency airway management have the appropriate skills and training.
	Observation bed use met selected requirements: • The facility gathered data regarding appropriateness of observation bed usage. • The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more.		
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee reviewed episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • The facility collected data that measured performance in responding to events.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.	• The Surgical Work Group only met 10 times over the past 12 months.	**2.** We recommended that the Surgical Work Group meet monthly.
NA	Clinicians appropriately reported critical incidents.		
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.		
	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.		
X	The policy for scanning internal forms into EHRs included the following required items: • Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate. • A correction process if scanned items have errors.	• The scanning policy did not include the quality of the source document, an alternative means of capturing data when the quality of the source document does not meet image quality controls, and a complete review of scanned documents to ensure readability and retrievability.	**3.** We recommended that the quality control policy for scanning include the quality of the source document, an alternative means of capturing data when the quality of the source document does not meet image quality controls, and a complete review of scanned documents to ensure readability and retrievability.

NM	Areas Reviewed (continued)	Findings	Recommendations
	• A complete review of scanned documents to ensure readability and retrievability of the record and quality assurance reviews on a sample of the scanned documents.		
X	Overall, if QM reviews identified significant issues, the facility took actions and evaluated them for effectiveness.	• The facility did not consistently document actions and evaluate them for effectiveness in the Quality, Safety, and Value; Critical Care; Medical Records; and Infection Prevention and Control Committees and in the EOC Council.	**4.** We recommended that the facility consistently document actions when data analyses indicated problems or opportunities for improvement and evaluate them for effectiveness in the Quality, Safety, and Value; Critical Care; Medical Records; and Infection Prevention and Control Committees and in the Environment of Care Council.
	Overall, senior managers actively participated in performance improvement over the past 12 months.		
	Overall, the facility had a comprehensive, effective QM program over the past 12 months.		
	The facility met any additional elements required by VHA or local policy.		

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. We also determined whether the facility met selected requirements in emergency management.[b]

At the Temple division, we inspected a critical care unit; two medical/surgical and two community living center units; the Emergency Department; a primary care clinic; and the wound care, dental, and orthopedic outpatient clinics. At the Waco division, we inspected the MH inpatient and psychiatric intensive care units; two community living center units; a primary care clinic; and the dental, eye, and women's health outpatient clinics. Additionally, we reviewed relevant documents, including 20 employee training and competency records (10 Temple division and 10 Waco division), and conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings	Recommendations
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.	Six months of EOC Council meeting minutes reviewed: • Minutes did not consistently track corrective actions to closure.	See recommendation 4 under QM.
	The facility conducted an infection prevention risk assessment.		
X	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.	Eight months of Infection Prevention and Control Committee meeting minutes reviewed: • Minutes did not consistently reflect follow-up on actions implemented to address identified problems.	See recommendation 4 under QM.
	The facility had established a process for cleaning equipment.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	The facility met fire safety requirements.		
	The facility met environmental safety requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for SCI Center		
NA	The facility completed and documented required inspection checklists of all ceiling mounted patient lifts.		
NA	The facility met fire safety requirements in the SCI Center.		
NA	The facility met environmental safety requirements in the SCI Center.		
NA	The facility met infection prevention requirements in the SCI Center.		
NA	The facility met medication safety and security requirements in the SCI Center.		
NA	The facility met patient privacy requirements in the SCI Center.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Emergency Management		
	The facility had a documented Hazard Vulnerability Assessment and reviewed the assessment annually.		
	The facility maintained a list of resources and assets it may need during an emergency.		

NM	Areas Reviewed for Emergency Management (continued)	Findings	Recommendations
	The facility had a written Emergency Operations Plan that addressed key components.		
	The facility had a written description of how it will respond to an influx of potentially infectious patients and a plan for managing them over an extended period of time.		
	Employees received training and competency assessment on use of emergency evacuation devices.		
	Evacuation devices were immediately accessible and in good repair.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Construction Safety		
NA	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		
NA	The facility complied with any additional elements required by VHA or local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility had established safe medication storage practices in accordance with VHA policy and Joint Commission standards.[c]

We reviewed relevant documents, the training records of 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected a critical care and medical/surgical unit, the post-anesthesia care unit, and the Emergency Department and for these areas reviewed documentation of overrides and narcotic wastage from automated dispensing machines and inspected crash carts containing emergency medications. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy addressed medication receipt in patient care areas, storage procedures until administration, and staff authorized to have access to medications and areas used to store them.		
	The facility required two signatures on controlled substances partial dose wasting.		
	The facility defined those medications and supplies needed for emergencies and procedures for crash cart checks, checks included all required elements, and the facility conducted checks with the frequency required by local policy.		
	The facility prohibited storage of potassium chloride vials in patient care areas.		
NA	If the facility stocked heparin in concentrations of more than 5,000 units per milliliter in patient care areas, the Chief of Pharmacy approved it.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility maintained a list of the look-alike and sound-alike medications it stores, dispenses, and administers; reviewed this list annually and ensured it was available for staff reference; and had labeling/storage processes to prevent errors.		
	The facility identified in writing its high-alert and hazardous medications, ensured the high-alert list was available for staff reference, and had processes to manage these medications.		
	The facility conducted and documented inspections of all medication storage areas at least every 30 days, fully implemented corrective actions, and monitored the changes.		
	The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy.		
	The facility employed practices to prevent wrong-route drug errors.		
	Medications prepared but not immediately administered contained labels with all required elements.		
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility met multi-dose insulin pen requirements.		
	The facility complied with any additional elements required by VHA or local policy.		

Coordination of Care

The purpose of this review was to evaluate the consult management process and the completion of inpatient clinical consults.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 34 randomly selected patients who had a consult requested during an acute care admission from January 1 through June 30, 2014. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	A committee oversaw the facility's consult management processes.		
	Major bed services had designated employees to: • Provide training in the use of the computerized consult package • Review and manage consults		
	Consult requests met selected requirements: • Requestors included the reason for the consult. • Requestors selected the proper consult title. • Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.		
	The facility met any additional elements required by VHA or local policy.		

CT Radiation Monitoring

The purpose of this review was to determine whether the facility complied with selected VHA radiation safety requirements and to follow up on recommendations regarding monitoring and documenting radiation dose from a 2011 report, *Healthcare Inspection – Radiation Safety in Veterans Health Administration Facilities*, Report No. 10-02178-120, March 10, 2011.[e]

We reviewed relevant documents, including qualifications and dosimetry monitoring for seven CT technologists and CT scanner inspection reports, and conversed with key managers and employees. We also reviewed the EHRs of 50 randomly selected patients who had a CT scan January 1–December 31, 2014. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
	The facility had a CT/imaging/radiation safety policy or procedure that included: • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance • CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans		

NM	Areas Reviewed (continued)	Findings	Recommendations
	A radiologist, technologist expert in CT, and medical physicist reviewed all CT protocols revised during the past 12 months, and a medical physicist tested a sample of CT protocols at least annually.		
	A medical physicist performed and documented CT scanner annual inspections, an initial inspection after acquisition, and follow-up inspections after repairs or modifications affecting dose or image quality prior to the scanner's return to clinical service.		
NA	If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review, and any summary reports provided by teleradiology included dose information.		
	CT technologists had required certifications or written affirmation of competency if "grandfathered in" prior to January 1987, and technologists hired after July 1, 2014, had CT certification.		
	There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring.		
	If required by local policy, CT technologists had documented training on dose reduction/optimization techniques and safe procedures for operating the types of CT equipment they used.		
	The facility complied with any additional elements required by VHA or local policy.		

ADs

The purpose of this review was to determine whether VHA facilities complied with selected requirements for ADs for patients.[f]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 49 randomly selected patients who had an acute care admission January 1–December 31, 2014. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles		
	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.		
	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.		
X	When inpatients requested a discussion about ADs (create, change, and/or revoke), employees: • Documented the discussion • Used the required AD note titles	• None of the 13 applicable EHRs contained documentation that employees asked patients if they wanted to have a discussion about their existing ADs. • Seven of the 12 applicable EHRs did not contain documentation that employees held requested discussions.	**5.** We recommended that employees offer patients the opportunity to review, revise, or rescind previously completed advance directives and document the discussions and that facility managers monitor compliance. **6.** We recommended that employees hold advance directive discussions requested by inpatients and document the discussions and that facility managers monitor compliance.
	The facility met any additional elements required by VHA or local policy.		

Surgical Complexity

The purpose of this review was to determine whether the facility provided selected support services appropriate to the assigned surgical complexity designation.[g]

We reviewed relevant documents and the training records of 20 employees, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.		
X	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.	• Two of three employees in respiratory therapy did not have 12-lead electrocardiogram competency assessment and validation documentation completed.	**7.** We recommended that facility managers ensure that respiratory therapy employees have 12-lead electrocardiogram competency assessment and validation completed and documented.
	The facility properly reported surgical procedures performed that were beyond the facility's surgical complexity designation. • The facility reviewed and implemented recommendations made by the VISN Chief Surgical Consultant.		
	The facility complied with any additional elements required by VHA or local policy.		

EAM

The purpose of this review was to determine whether the facility complied with selected VHA out of operating room airway management requirements.[h]

We reviewed relevant documents, including competency assessment documentation of 22 clinicians applicable for the review period January 1–June 30, 2014, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
NA	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
X	Facility policy addressed key VHA requirements, including: • Competency assessment and reassessment processes • Use of equipment to confirm proper placement of breathing tubes • A plan for managing a difficult airway	• Facility policy did not address an alternative for new employees, transfers from other VA medical centers, consultants or without compensation clinicians, or the availability of portable video laryngoscopes for use by clinicians for EAM.	**8.** We recommended that the facility revise the emergency airway management policy to include an alternative for new employees, transfers from other VA medical centers, consultants or without compensation clinicians, and the availability of portable video laryngoscopes for use by clinicians for emergency airway management.

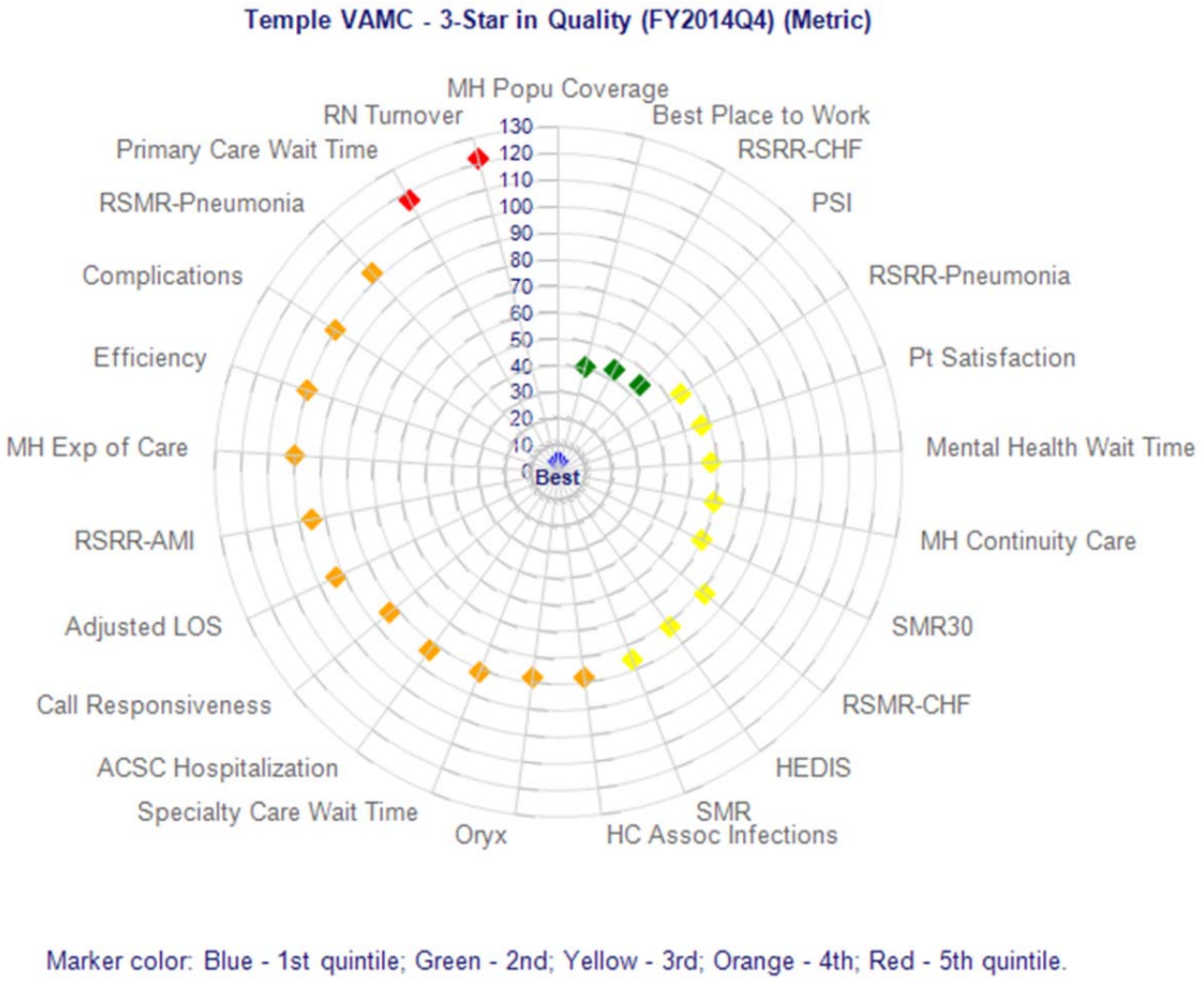
NM	Areas Reviewed (continued)	Findings	Recommendations
X	Initial competency assessment for EAM included: • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • Successful demonstration of procedural skills on patients	• Twelve of the 22 clinicians did not have evidence of successful demonstration of all required procedural skills on patients.	**9.** We recommended that the facility ensure initial clinician emergency airway management competency assessment includes evidence of successful demonstration of all required procedural skills on patients and that facility managers monitor compliance.
NA	Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included: • Review of clinician-specific EAM data • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • At least one occurrence of successful airway management and intubation in the preceding 2 years, written certification of competency by the supervisor, or successful demonstration of skills to the subject matter expert • A statement related to EAM if the clinician was not a licensed independent practitioner		
X	The facility had a clinician with EAM privileges or scope of practice or an anesthesiology staff member available during all hours the facility provided patient care.	• None of the 30 sampled days had EAM coverage during all hours the facility provided patient care.	**10.** We recommended that the facility ensure a clinician with emergency airway management privileges or scope of practice or an anesthesiology staff member is available during all hours the facility provides patient care and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Temple/674) FY 2015 through April 2015[1]	
Type of Organization	Secondary
Complexity Level	1b-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$577.8
Number (as of March) of:	
• **Unique Patients**	78,866
• **Outpatient Visits**	542,345
• **Unique Employees**[2]	3,126
Type and Number of Operating Beds (as of March):	
• **Hospital**	163
• **Community Living Center**	210
• **MH**	332
Average Daily Census (as of March):	
• **Hospital**	109
• **Community Living Center**	160
• **MH**	212
Number of Community Based Outpatient Clinics	6
Location(s)/Station Number(s)	Austin/674BY Palestine/674GA Brownwood/674GB College Station/674GC Cedar Park/674GD La Grange/674HB
VISN Number	17

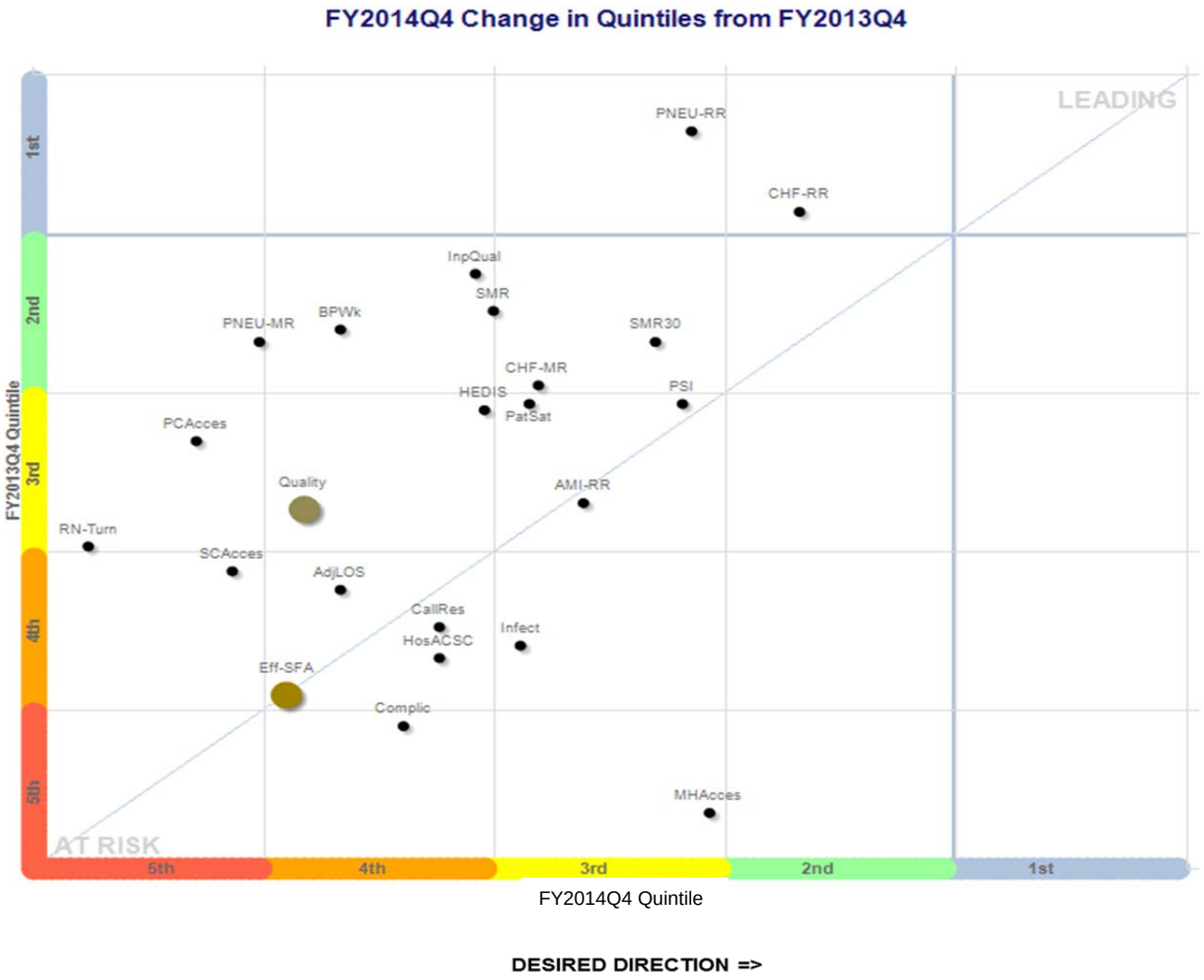
[1] All data is for FY 2015 through April 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

Strategic Analytics for Improvement and Learning (SAIL)[3]



[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

Acting VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: June 29, 2015

From: Acting Director, VA Heart of Texas Health Care Network (10N17)

Subject: **CAP Review of the Central Texas Veterans Health Care System, Temple, TX**

To: Director, Dallas Office of Healthcare Inspections (54DA)

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. Thank you for allowing me to respond to this CAP Review for the Central Texas Veterans Health Care System (CTVHCS).

2. I have reviewed and concur with the findings of this report. Specific corrective actions have been provided for the recommendations.

3. Should you have any questions, please contact Denise Elliot, VISN 17 Quality Management Officer at (817)-385-3734.

Wendell Jones
Acting Director, VA Heart of Texas Health Care Network (10N17)

Acting Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: June 29, 2015

From: Acting Director, Central Texas Veterans Health Care System (674/00)

Subject: **CAP Review of the Central Texas Veterans Health Care System, Temple, TX**

To: Director, VA Heart of Texas Health Care Network (10N17)

1. On behalf of Central Texas Veterans Health Care System, I would like to take this opportunity to express my sincere appreciation to the Office of the Inspector General (OIG), Combined Assessment Program (CAP) review team for their professionalism, consultive approach, and excellent feedback provided to our staff during the review conducted the week of April 13, 2015.

2. The recommendations were reviewed and I concur with the findings. Our comments and implementation plan are delineated below. Corrective action plans have been developed or executed for continual monitoring. Texas Veterans Health Care System welcomes the external perspective provided, which we will utilize to further strengthen the quality of care we provide to our veterans.

3. Should you have questions or require additional information, please do not hesitate to contact Sylvia Tennet, Chief of Quality Management and Improvement Service at (254)-743-0719.

Acting Director, Central Texas Veterans Health Care System (674/00)

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that facility managers ensure that licensed independent practitioners who perform emergency airway management have the appropriate skills and training.

Concur

Target date for completion: Completed June 14, 2015

Facility response: CTVHCS procedures have been modified that only Emergency Management certified staff are on hospitalist schedule. The following information relates to Licensed Independent Practitioners providing Out of Operating Room Airway Management since May 1, 2015. Twelve of the 13 hospitalist completed by May 13, 2014 and one hospitalist completed the training on May 19, 2015. Of the two MOD's, one completed training on May 14, 2015, and June 14, 2015. As of February 28, 2015, all hospitalists have been privileged for Out of Operating Room Airway Management. The two MODs are Out of Operating Room Airway Management privileged as of June 14, 2015.

Recommendation 2. We recommended that the Surgical Work Group meet monthly.

Concur

Target date for completion: December 31, 2015

Facility response: The Surgical Workgroup has designated an alternative Surgical Service Chief to convene the Surgical Workgroup meetings during the absence of the Associate Chief of Staff. Effective April 27, 2015, monthly meetings will be held to comply with VHA Handbook 1102.01 National Surgery Office. Reports will be submitted to the Clinical Executive Council (CEC) monthly for oversight monitoring, starting July 20, 2015. Additionally, the CEC reports to the Executive Leadership Board (ELB).

Recommendation 3. We recommended that the quality control policy for scanning include the quality of the source document, an alternative means of capturing data when the quality of the source document does not meet image quality controls, and a complete review of scanned documents to ensure readability and retrievability.

Concur

Target date for completion: July 1, 2015

Facility response: The CTVHCS Scanning Policy Number 136-023 has been revised to incorporate the required elements and is currently in the concurrence process.

Recommendation 4. We recommended that the facility consistently document actions when data analyses indicated problems or opportunities for improvement and evaluate them for effectiveness in the Quality, Safety, and Value; Critical Care; Medical Records; and Infection Prevention and Control Committees and in the Environment of Care Council.

Concur

Target date for completion: September 30, 2015

Facility response: CTVHCS Oversight Council Chairs will be tasked with ensuring the documentation of data analysis that identified problems or opportunities for improvements are evaluated for effectiveness in the Quality, Safety, and Value Council, Critical Care Committee, Medical Records Committee, Infection Prevention and Control and the Environment of Care Committee (EOC). This approach constitutes the council chairs validating the process following each meeting, including the following to align with the current CTVHCS Meeting Minutes Policy Number 00-029:

- The Chair Environment of Care Committee (EOC) will ensure the meeting minutes consistently track corrective actions to closure.

- The Chair of the Infection Prevention and Control Committee will ensure that the meeting minutes reflect follow-up actions, and the actions identified are consistently executed to address identified problems.

Random monthly audits of Quality, Safety, and Value Council, Critical Care Committee, Medical Records Committee, Infection Prevention and Control, and EOC meeting minutes will be conducted by the Quality Management Committee Facilitators for compliance starting June 30, 2015. Compliance rate is established at 90% or >. Trended aggregated reports will be submitted to the respective council/committees. Additionally, the Executive Council of the Governing Body will also receive these reports monthly.

Recommendation 5. We recommended that employees offer patients the opportunity to review, revise, or rescind previously completed advance directives and document the discussions and that facility managers monitor compliance.

Concur

Target date for completion: December 31, 2015.

Facility response: The Chief, Social Work Service met with CEC members on June 2, 2015 and discussed process change regarding mandatory provider discussions to offer patients the opportunity to revise, or rescind previously completed ADs and then place them in the correct AD note title. Monitoring for compliance with AD note title will

begin August 31, 2015. Social Work Service leadership will offer educational outreach to the affected services. The established date for full compliance to be achieved is December 31, 2015. A sample size of 50 randomly selected cases will be audited monthly. The target compliance rate is established at 90% or >. Monthly compliance monitoring reports will be submitted to the CEC, and the Executive Leadership Board.

Recommendation 6. We recommended that employees hold advance directive discussions requested by inpatients and document the discussions and that facility managers monitor compliance.

Concur

Target date for completion: December 31, 2015

Facility response: The Chief, Social Work Service met with the CEC members on June 2, 2015 and discussed process change for employees to hold AD discussions requested by inpatient and document the discussions in the correct AD note title. The Monitoring of compliance with AD note titles will be initiated on August 31, 2015.

The Social Work Service leadership will offer educational outreach to affected services with a target completion date of July 31, 2015. Education will be provided at Social Work, Nursing, and Medical Provider staff meetings. This will be monitored by the Chief/Assistant Chief, Social Work Service, and the Facility Advanced Directives Workgroup members. Target compliance rate is established at 90% or >. Monthly compliance monitoring reports will be submitted to the CEC, and the Executive Leadership Board.

Recommendation 7. We recommended that facility managers ensure that respiratory therapy employees have 12-lead electrocardiogram competency assessment and validation completed and documented.

Concur

Target date for completion: Completed

Facility response: All of the 27 Respiratory Therapists (RTs) Unit employees' Competency Assessments for the 12-lead electrocardiogram (EKG) were reviewed and validation completed by Respiratory Supervisor/Assistant RT Supervisors on May 10, 2015 with 100% compliance. Monitoring will be conducted during annual evaluation.

Recommendation 8. We recommended that the facility revise the emergency airway management policy to include an alternative for new employees, transfers from other VA medical centers, consultants or without compensation clinicians, and the availability

of portable video laryngoscopes for use by clinicians for emergency airway management.

Concur

Target date for completion: August 30, 2015

Facility response: CTVHCS Emergency Airway Policy number 115-006 is being revised to reflect the relevant portions of the VHA Directive number 2012-032 titled "Out of Operating Room Airway Management." The revised policy will be submitted to the CEC for review by August 30, 2015.

Recommendation 9. We recommended that the facility ensure initial clinician emergency airway management competency assessment includes evidence of successful demonstration of all required procedural skills on patients and that facility managers monitor compliance.

Concur

Target date for completion: June 16, 2015

Facility response: CTVHCS has ensured that emergency airway management competency assessment includes evidence of successful demonstration of all required procedural skills on patients and is in compliance. The Associate Chief of Staff, Medicine service will report the rate of compliance monthly to the CEC beginning June 16, 2015. Additionally, the CEC reports to the Executive Leadership Board.

Recommendation 10. We recommended that the facility ensure a clinician with emergency airway management privileges or scope of practice or an anesthesiology staff member is available during all hours the facility provides patient care and that facility managers monitor compliance.

Concur

Target date for completion: December 31, 2015

Facility response: CTVHCS has initiated a process in which Medical Service will provide coverage with the Hospitalists. The Associate Chief of Staff Medicine Service will ensure that the covering hospitalists have the required training in emergency airway management and privilege, or scope of practice. Monitoring will be conducted by the Associate Chief of Staff Medicine Service and reports will be submitted monthly to the CEC. Additionally, reports will be submitted to the Executive Leadership Board.

Office of Inspector General
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Endnotes

[a] References used for this topic included:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[b] References used for this topic included:
- VHA Directive 2008-052, *Smoke-Free Policy for VA Health Care Facilities*, August 26, 2008.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VA National Center for Patient Safety, "Issues continue to occur due to improper ceiling mounted patient lift installation, maintenance and inspection," Addendum to Patient Safety Alert 14-07, September 3, 2014.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, Underwriters Laboratories, VA Master Specifications.

[c] References used for this topic included:
- VHA Directive 2008-027, *The Availability of Potassium Chloride for Injection Concentrate USP*, May 13, 2008.
- VHA Directive 2010-020, *Anticoagulation Therapy Management*, May 14, 2010.
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of The Joint Commission.

[d] The reference used for this topic was:
- Under Secretary for Health, "Consult Business Rule Implementation," memorandum, May 23, 2013.

[e] References used for this topic included:
- VHA Directive 1129, *Radiation Protection for Machine Sources of Ionizing Radiation*, February 5, 2015.
- VHA Handbook 1105.02, *Nuclear Medicine and Radiation Safety Service*, December 10, 2010.
- VHA Handbook 5005/77, *Staffing*, Part II, Appendix G25, Diagnostic Radiologic Technologist Qualifications Standard GS-647, June 26, 2014.
- The Joint Commission, "Radiation risks of diagnostic imaging," Sentinel Event Alert, Issue 47, August 24, 2011.
- VA Radiology, "Online Guide," updated October 4, 2011.
- The American College of Radiology, "ACR–AAPM TECHNICAL STANDARD FOR DIAGNOSTIC MEDICAL PHYSICS PERFORMANCE MONITORING OF COMPUTED TOMOGRAPHY (CT) EQUIPMENT, Revised 2012.

[f] The references used for this topic included:
- VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[g] References used for this topic included:
- VHA Directive 2009-001, *Restructuring of VHA Clinical Programs*, January 5, 2009.
- VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.

[h] References used for this topic included:
- VHA Directive 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.